Journal of Gay & Lesbian Mental Health, 14:94–108, 2010
ISSN: 1935-9705 print / 1935-9713 online
DOI: 10.1080/19359701003622875

Routledge
Taylor & Francis Group

ORIGINAL RESEARCH

Transgender Clients: Identifying and Minimizing Barriers to Mental Health Treatment

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This study examined mental healthcare use and barriers to mental healthcare utilization in a sample of 130 transgender volunteers. Roughly a third of participants sought treatment for mental health issues including depression, anxiety, and relationship problems. Sixty-eight participants (52% of sample) showed evidence of psychological distress but had not received mental health services in the past year. Results point to potential barriers to seeking mental health services. Specifically, cost of treatment, previous bad experiences with healthcare, fear of treatment, and stigma concerns were the most frequently endorsed barriers related to seeking mental health services. Implications for practitioners are discussed.

KEYWORDS transgender, transsexual, barriers to care, minority, stigma, mental health

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INTRODUCTION

Research suggests that there are ethnicity and sex-related disparities in mental healthcare access (e.g., Beckman & Amaro, 1986; Egede & Bosworth, 2008; Grubaugh, Slagle, Long, Frueh, & Magruder, 2008; Schober & Annis, 1996). Transgender patients could experience barriers to care similar to those experienced by women and ethnic minorities due to their gender-minority status (Maguen, Shipherd, & Harris, 2005). Indeed, insensitivity of healthcare workers and outright discrimination have been reported by transgender individuals as barriers to healthcare utilization (Bockting, Robinson, & Rosser, 1998; Clements, Wilkinson, Kitano, & Marx, 1999; Lombardi, 2001; Sperber, Landers, & Lawrence, 2005). Overall, research suggests the need to improve the cultural competence in the healthcare system of the transgender population in order to better meet the needs of the transgender community (Kenagy, 2005; Sperber et al., 2005; Xavier, 2000). Within this literature, mental healthcare barriers have yet to be specifically examined in transgender samples.

Little is known about the mental health functioning and clinical needs of transgender individuals. The existing literature on health issues within transgender populations largely focuses on HIV/AIDS, suicide, violence, and abuse (Kenagy, 2005; Shipherd, Maguen, Skidmore, & Abramovitz, 2010). These are important issues to study, yet they do not provide a full clinical picture. Mental health clinicians need to be aware of both the patterns of treatment seeking, typical presenting complaints, and the potential barriers transgender individuals face in seeking mental health treatment.

Some providers may fear that they lack the expertise to treat transgender clients in a culturally competent manner. Yet the literature that does exist on transgender mental health issues suggests that mental health treatment needs within this population reflect many of the same areas of presenting complaints (e.g., anxiety disorders, depression, substance use) as in the general community and are sometimes peripheral or unrelated to gender issues (Sperber et al., 2005). Dean et al. (2000) remarked that "transgender persons exhibit mental health problems that are comparable to those seen in other persons who experience major life changes, relationship difficulties, chronic medical conditions, or significant discrimination on the basis of minority status" (Dean et al., 2000, p. 129). These problem areas are quite amenable to mental health treatment and can be treated appropriately by practitioners skilled in these areas if they are willing to develop some culturally competent knowledge, but should not require expertise in gender identity counseling per se.

Once practitioners identify the applicability of their skill-sets to address mental health issues within the transgender community, an important next step is to identify what barriers may prevent transgender individuals from utilizing mental healthcare services. The Institute of Medicine's (IoM) report on disparities of care (Smedley et al., 2003) and subsequent recommendations

about eliminating disparities (Williams, 2007) highlight the role of (1) increasing provider awareness that such disparities exist and (2) improving access for minority populations to the standard of care treatments for particular problem areas, within a culturally sensitive framework. It is important for practitioners to understand what perceived barriers to care are present for potential clients who identify as transgender. It can be appreciated that perceptions of mental healthcare can directly influence treatment-seeking behavior, or lack thereof. As an element of cultural competence, it is important for practitioners to be aware of how mental health treatment is perceived by the transgender community and what barriers exist to accessing this care. In this way, it is possible for practitioners to improve access to their services by this underserved minority population. Theoretically, understanding what barriers exist for transgender potential clients can assist practitioners in improving outreach efforts, access to their services, and likely reduce no-show rates and cancellations when treating transgender clients.

Sperber (2005) identified various barriers that may prevent transgender individuals from accessing mental health treatment using focus groups with a small sample ($n = 34$). This research showed that provider ignorance about transgender care and insensitivity to transgender needs were the primary problems when accessing mental health treatment. In addition, outright discrimination and upsetting interactions with mental healthcare professionals were noted (Sperber et al., 2005). However, these results have not been replicated or examined in larger samples.

The current study expands the literature in this field by exploring mental healthcare needs, mental healthcare use, and perceived barriers to mental healthcare service utilization in a larger sample of transgender individuals. This study is an important initial investigation of mental healthcare utilization, psychological distress, and perceived barriers in a transgender sample. Being informed about types of care being accessed by transgender clients and specific barriers that prevent service utilization are important goals for providers. In particular, determining what prevents healthcare utilization when symptoms are present can facilitate addressing the Institute of Medicine's charge of bringing evidence-based treatments to an underserved minority population. In this way, the current study addresses the need for empirical research to inform providers who are seeking to expand their practice to make services accessible to transgender clients.

METHOD

Participants and Procedures

Transgender individuals were recruited in January 2008 at an annual transgender conference held in a suburb of Boston, Massachusetts. The conference featured educational workshops, social events, and vendors specializing

in products of interest to the transgender community. Conference attendees were recruited for the research by investigators who were stationed at a table in the vendor room of the conference venue.

Participants responded to an anonymous survey that included a variety of measures assessing demographics, psychological and physical distress, treatment history, barriers to healthcare service utilization, and treatment preferences. When possible, measures with high reliability and validity were selected. Investigators were nearby throughout survey administration to answer any questions from potential participants. To protect confidentiality, participants were not asked to sign an informed consent form or provide any personally identifying information. Instead, a cover sheet outlining the key elements of informed consent was the first page of the survey as approved under IRB review. Upon completion of the survey, participants were asked to place the survey face down in a collection box and were given information regarding transgender-friendly healthcare resources. Participants were not paid for their participation.

Transgender individuals of multiple genders, sexual orientations, and ethnic backgrounds were included in the current study. The sample consisted of 130 self-identified transgender volunteers who ranged in age from 22 to 79 ($M = 49.24$; $SD = 10.96$) and were primarily Anglo-Caucasian (92%). Table 1 summarizes the demographic characteristics of the sample. Nearly 49% of the sample identified as male-to-female transsexual, and 36% identified as male-to-female crossdresser; only 7% identified as female-to-male transsexual or crossdresser. Consistent with this breakdown, 50% ($n = 65$) endorsed seeking gender identity counseling in the past year, 55 participants endorsed taking hormone therapy (42%), and 9 participants had undergone surgical procedures (e.g., breast enlargement or reduction) as part of gender transition (7%).[1] The sample was highly educated (65% with at least a college degree) and employed (69% full-time; 12% retired). The vast majority of the sample (95%) reported that they had health insurance.

Measures

Demographics

Participants were assessed on a wide range of demographic characteristics including age, gender identity, ethnicity, employment and retiree status, education, veteran status, homelessness, and health insurance status (see Table 1).

Perceived Mental Health

The Short Form-12 Survey (SF-12; Ware, Kosinski, & Keller, 1996) is a measure of general physical and psychological health. However, for the purposes

TABLE 1 Demographics of Entire Sample

Variable	Sample (N = 130)
Age	M = 49.24 (SD = 10.96) Range 22–79
Gender identity	
MtF Transsexual (trans woman)	49%
MtF crossdresser	36%
FtM transsexual or crossdresser	7%
Gender nonconformist or gender outlaw	3%
Gender questioning	4%
Intersexed	1%
Ethnicity	
Caucasian	92%
Latino/Hispanic	1.5%
Asian	1%
Other	4%
(No answer)	1.5%
Education	
High school	9%
Some college	16%
Associates degree	10%
Bachelors degree	37%
Masters degree	16%
Professional degree	5%
Doctorate	5%
(No answer)	2%
Employment	
Full time	69%
Part time	5%
Student	2%
Retired	12%
Unemployed	8%
Service connected or Social Security disabled	3%
(No answer)	1%
Health insurance	
Yes	95%
No	5%
Gender identity counseling	
Yes	50%
No	50%

of this study, only psychological functioning was evaluated. As per the scoring manual (Ware, Kosinski, & Keller, 1995), responses to the six items about perceived mental health were summed and a composite t-score was calculated via the scoring manual algorithm derived from a representative sample of the U.S. population (Ware et al., 1995). The resulting mental health composite scores can potentially range from 0 (worst health) to 100 (best health) and are weighted to have a mean score of 50 and a standard deviation of 10. Thus, scores of 40 or lower indicate distress as indicated by being more than one standard deviation below population norms. In the current study, participants scoring 40 or below on the mental health scale were classified

as "in need of mental health services." Test-retest reliability of the mental health subscale is good at two weeks (rtt = 0.76; Ware et al., 1996). In addition, the SF-12 has differential validity discriminating between patients with serious and minor mental health problems and is highly correlated with the well-validated SF-36 (rtt = 0.97; Ware et al., 1996).

Treatment History

Participants were asked about personal treatment history from the past year for numerous mental health conditions. The items were based on the 2006 National Health Interview Study (National Center for Health Statistics, 2007). Gender identity counseling was added to this measure. In addition, participants were asked whether or not they had received treatment for the following mental health problems in the past year: (1) drug abuse and/or alcoholism; (2) post-traumatic stress disorder; (3) anxiety, worry, or panic attacks; (4) depression or excessive sadness; (5) grief or bereavement; (6) eating disorders; (7) sleep problems; and (8) relationship or marital problems.

Service Utilization Barriers Scale

The Service Utilization Barriers Scale (SUBS) was developed specifically for this study. The SUBS was used because no existing measure assessed a comprehensive list of potential barriers that might prevent individuals from utilizing mental health services. Therefore, the SUBS was developed by incorporating aspects of various validated measures (Bauer, Williford, McBride, McBride, & Shea, 2005; Hoge et al., 2004; Miller, Sovereign, & Krege, 1988) to form a composite measure that assessed institutional/systemic barriers and internal/intrapersonal barriers to mental health services. Items were phrased as beliefs/cognitions and are listed in Table 2. Each item was rated on a Likert scale from 1 (strongly disagree) to 5 (strongly agree) and then dichotomized into a barrier/not a barrier scale (barrier = agree or strongly agree, not a barrier = disagree, strongly disagree or neutral). This dichotomization was necessary to facilitate interpretation of data.

RESULTS

To examine service use and barriers to treatment seeking, participants were divided into four groups based on mental health treatment history (yes/no for past year's use of mental health services) and level of psychological distress (elevated/normal) as measured by the mental health composite score from the SF-12. Table 3 summarizes the distribution of respondents into the

TABLE 2 Mental Healthcare Barriers in Order of Endorsement for Full Sample (N = 130)

SUBS Item	*n* endorsing	% of Sample
1. Health services costs too much	54	42%
2. Somebody I know or heard about had a bad experience with health services	42	32%
3. I don't like to talk about my personal life with other people	29	22%
4. I don't like to talk in groups	28	22%
5. I don't want to be put on medication for my problems	27	21%
6. I don't want a health problem to enter into my medical record	25	19%
7. I would be seen as less competent as a person	23	18%
8. I don't know what would happen to me	21	16%
9. I've had a bad experience with health services before	20	15%
10. It would be difficult to find the time for health services due to other commitments (e.g., work, family, friends)	20	15%
11. People would see me as weak	19	15%
12. I would be seen as fundamentally flawed	19	15%
13. I would be less accepted by my friends	18	14%
14. People wouldn't trust me	18	14%
15. I am afraid I'd be put into a hospital	15	12%
16. I would be afraid of the reaction of a doctor or counselor to my gender identity	14	11%
17. I would be less accepted by my family	13	10%
18. People would make fun of me	13	10%
19. People would avoid me	13	10%
20. I have no insurance to pay for health services	12	9%
21. I am afraid of what might happen in health services	12	9%
22. I would be afraid of the reaction of a doctor or counselor to my sexual orientation	12	9%
23. People would see me as more likely to be violent or dangerous	11	9%
24. I wouldn't get the type of health services I want	10	8%
25. I don't trust health service professionals	10	8%
26. I am afraid I would see someone I know if I went for health services	10	8%
27. Going to health services would harm my career	10	8%
28. I have problems getting enough time during appointments with providers	9	7%
29. I think I would lose my friends if I went for help	9	7%
30. Health services are for people who with worse problems than mine	9	7%
31. I have problems getting convenient, routine appointments, or notification of appointments (e.g., times of day or week needed were not available)	9	7%
32. I think my troubles will just go away without any health services	9	7%
33. It's difficult to schedule a health service appointment	9	7%
34. I think that going for help might get me in legal trouble	9	7%
35. Health services wouldn't do me any good	7	5%
36. It is too far to travel for health services	6	5%
37. Health services don't work	6	5%

(Continued on next page)

TABLE 2 Mental Healthcare Barriers in Order of Endorsement for Full Sample (N = 130) *(Continued)*

SUBS Item	*n* endorsing	% of Sample
38. It is too hard to find childcare so that I could go for health services	6	5%
39. Other people have discouraged me from seeking health services	6	5%
40. I don't know where to go to get health services	5	4%
41. I have differences in religion, culture, or personal values between me and my provider	5	4%
42. I am afraid that I would not be safe or would be harassed/ attacked in a health service environment	4	3%
43. I wouldn't feel safe going where I'd have to go for help	4	3%
44. I don't have adequate transportation	3	2%
45. Going to health services would be too embarrassing	3	2%
46. I have problems understanding the providers' instructions for health services	1	0.8%

following categories: (1) no current need for mental health services (as per SF-12) and no use of mental health services past year, (2) no current need for services but used mental health services in the past year, (3) current distress but no use of mental health services in the past year, and (4) current distress and use of mental health services in the past year.

First, we evaluated the types of services sought by the participants. Forty-eight individuals accessed treatment for mental health problems other than gender identity counseling in the past year (37%). The most common problem for which respondents received treatment in the past year was depression or excessive sadness ($n = 26$; 20%). This presenting complaint was followed closely by anxiety, worry, or panic attacks ($n = 25$; 19%) and relationship or marital problems ($n = 24$; 18.5%). Other less common presenting mental health problems respondents sought treatment for in the past year included post-traumatic stress disorder ($n = 12$; 9%), sleep problems ($n = 11$; 8.5%), grief or bereavement ($n = 8$; 6%), eating or weight disturbances ($n = 4$; 3%), and drug abuse and/or alcoholism ($n = 2$; 1.5%).

TABLE 3 Sample Distribution by Mental Health Treatment Need and Treatment History

	No current need for mental health treatment (SF-12 > 40)	Current need for mental health treatment (SF-12 ≤ 40)
No past year use of mental health services	14 (11%)	68 (52%)
Past year use of mental health services	18 (14%)	30 (23%)

TABLE 4 Most Frequently Endorsed Mental Healthcare Barriers in Subsample of 68 Respondents Who Reported Mental Health Difficulty But Did Not Seek Treatment

SUBS Item	*n* of sub- sample	% of sub- sample
COST		
Mental health services cost too much	25	37%
PAST BAD EXPERIENCES		
Somebody I know or heard about had a bad experience with mental health services	18	27%
I've had a bad experience with [mental health] services before	9	13%
FEAR OR DISLIKE OF TREATMENT ASPECTS		
I don't like to talk about their personal life with other people	14	21%
I don't want to be put on medications for my problems	14	21%
I don't like to talk in groups	12	18%
I don't know what would happen to me [if I went for services]	9	13%
I don't want a [mental] health problem to enter into my medical record	7	10%
I'm afraid I would be put into a hospital	7	10%
STIGMA CONCERNS		
I would be seen as fundamentally flawed	8	12%
People would see me as weak	7	10%
I would be seen as less competent as a person	7	10%
I would be less accepted by my friends	6	9%
I would be less accepted by my family	5	7%
People would make fun of me	5	7%
TIME LIMITATIONS		
It would be difficult to find time for services due to other commitments (e.g., work, family, friends)	8	12%

Second, we examined the item-level rates of endorsement for perceived barriers to mental healthcare service utilization in the entire sample (see Table 2). The most frequently endorsed barriers were related to cost of services (endorsed by 42%), hearing about bad experiences from others (32%), not liking to talk about personal life (22%), not liking to talk in groups (22%), and not wanting to be put on medications (21%).

To examine further the patterns of these perceived barriers, we evaluated the 68 participants (52% of sample) who showed evidence of a need for mental health services (as per SF-12 mental health scores) but did not utilize services. Table 4 summarizes the most frequently endorsed barriers for this subsample; the most frequently endorsed item was that mental health services cost too much ($n = 25$; 37%). The second tier of frequently endorsed items was knowing someone who had a past bad experience with mental health services ($n = 18$; 27%) or having a bad experience personally ($n = 9$; 13%). The third most frequently endorsed group of barriers was fear of

mental health services or dislike of certain aspects of psychological treatment (e.g., not liking to talk in groups or take medications). The fourth most frequently endorsed group of barriers was related to stigma concerns and fear of social consequences (e.g., being seen as weak or flawed).

DISCUSSION

Some useful suggestions for clinicians can be ascertained from these data. First, the types of services this group of transgender subjects accessed were primarily in areas that practitioners can provide "standards of care" treatment. Clinicians specializing in depression, anxiety, and relationship counseling would be well advised that transgender individuals may present for treatment and constitute an underserved population that could be a focus for advertising campaigns and/or outreach efforts. This underscores the fact that providers do not need to be trained in gender identity counseling per se to offer valuable services to the transgender community.

More importantly, research shows that provider ignorance and insensitivity to transgender issues are prevalent in the mental healthcare system, suggesting that small efforts in increasing cultural sensitivity to gender identity issues by providers can have large effects for the transgender community. Sperber (2005) reported that "sometimes gender issues are central to mental health or substance abuse treatment, sometimes they are peripheral and sometimes they are unrelated" (p. 76). In the current study, a substantial proportion of respondents (37%) reported accessing mental health services for problem areas such as depression, anxiety, and relationship distress in the past year. Therapists have specialized training in many empirically supported treatments for these problem areas and do not need to be experts in the transgender experience in order to provide culturally competent care. Instead, a patient's transgender status can be part of the individual context that informs case conceptualization and delivery of services, as would be the case with any other type of individual difference (e.g., sexual orientation, age, ethnicity).

As providers increase their culturally competent knowledge, barriers to treatment for transgender clients could be reduced. Indeed, among the barriers for participants who were in need of treatment but did not seek care were prior bad experiences with mental health (13%) or knowing someone with a bad past experience (27%). While the source of the dissatisfaction with past treatment is not known, a potential reason is lack of provider sensitivity. By providing professional, quality mental healthcare in a culturally informed manner, it is possible for providers to expand their practice and be more inclusive of a diverse clientele.

In terms of minimizing disparities in mental healthcare service utilization for the transgender population, important information to guide future

research was obtained about perceived barriers to mental health service utilization. Specific cognitions about mental health services were identified that may serve as barriers, thus preventing transgender individuals in need of treatment from using available services. Specifically, respondents endorsed that cost of treatment, fear of certain aspects of treatment (e.g., medications), and concerns about stigma or social consequence are salient factors that prevent transgender individuals in distress from seeking services. These patterns were found both for the entire sample and within the subsample of participants (52%) who endorsed having mental health difficulties yet did not seek mental health services.

It is difficult to draw comparisons between the rates of endorsement with the current transgender sample and those from other comparison groups. However, two studies were identified for rudimentary comparison, including a study of veterans and a study from the general population where barriers to healthcare use were reported. Bauer (2005) assessed veterans engaged in healthcare services in the VA system ($N = 324$). In the sample of veteran healthcare users, life commitments and telephone/travel difficulties constituted two domains of barriers that affected service utilization. However, mean scores were reported instead of rates of endorsement, and mental health services were not differentiated from medical services. Thus, comparisons with this earlier study are difficult but provide relevant context for the current findings.

In a study that might be more comparable to the current study, an Internet study assessed potential barriers to treatment in a sample of respondents who reported concern about their alcohol use ($n = 218$) but largely had not sought services for such (Green, 2008; Green & McCrady, 2009). That sample was largely female (71%), Caucasian (76%), and heterosexual (72%). Respondents were asked to rate barriers that prevented them from seeking treatment in the past, or that could potentially prevent them from seeking treatment in the future. In that sample, 67% endorsed one or more items related to negative attitudes about counseling (e.g., "somebody I know had a bad experience with treatment"), and 67% endorsed one or more items related to fear of treatment (e.g., "I didn't know what would happen to me"). Those findings are similar to the current study, where past bad experiences and fear or dislike of treatment aspects were endorsed by the transgender participants who reported psychological distress but had not sought treatment in the past year. Though these two studies cannot be directly compared due to methodological differences, it does suggest that prior bad experiences and fear or dislike of treatment constitute common barriers to service utilization across samples of nontreatment seeking distressed individuals, rather than being specific to the transgender community.

Similarly, Green (2008) reported that 60% of respondents endorsed one or more item related to stigma concerns (e.g., "I thought people would make fun of me"), and 55% endorsed one or more items related to fear of social

consequences (e.g., "I thought I'd lose friends if I went for help"). These categories are similar to the stigma category in the current study and in previous reports of veterans returning from combat who endorse distress but have not sought treatment due to stigma-related concerns associated with mental health treatment (Hoge et al., 2004). Together, the data suggest that the transgender community may simply share the same struggles and face the same barriers to accessing care that other groups report.

A particularly interesting finding of the current study was that despite the high rates of insurance in this sample (95%), the most commonly endorsed item-level barrier to accessing mental health services was their high cost. Cost was the primary barrier reported in the overall sample, and also in the subsample among those who were distressed but not seeking treatment. This finding could reflect an assumption that insurance does not cover mental health costs or could reflect a trend for transgender individuals to seek services with providers who are not part of insurance panels. Indeed, 12 participants in the overall sample endorsed lack of health insurance as a barrier to treatment, though only 7 participants were without any health insurance. Practitioners could potentially decrease this barrier by advertising a sliding scale or their involvement in insurance panels in lesbian, gay, bisexual, and transgender (LGBT)-friendly magazines or newspapers and specifically mentioning gender inclusion in all advertisements (e.g., Web sites).

In terms of potential ways to minimize the effects of stigma and/or fear of services as barriers, providers could engage in outreach efforts aimed to inform the community about services and the efficacy of such services. Providing education about the process of psychotherapy, the options available, and emphasis on patient-centered approaches could counter some of the fears related to mental health services for many types of new clients. Further, it could be important to emphasize that treatment is tailored to address individualized needs in a culturally sensitive framework. Small outreach efforts can attract patients if providers are willing to develop culturally competent skills (e.g., through consultation, readings, or additional training), which in turn will attract more clients via word-of-mouth referrals. The findings of the current study provide an initial foundation for practical implications for clinicians. However, it is important to acknowledge the limitations of this study.

The primary limitation of the current study is the use of self-report measures and only one indicator of psychological distress. These methods may limit the validity of the "psychological distress" classification and other variables of interest. Further, a comprehensive list of potential services was not assessed. For example, severe mental illness was not evaluated.

An additional limitation of the current study is that there was no matched comparison sample to demonstrate if similar barriers would be reported with another group. For example, it is possible that gay and lesbian clients would report similar perceived barriers to accessing treatment. Indeed, when

compared to similar studies (e.g., Bauer et al., 2005; Green & McCrady, 2009), it appears that many of the perceived barriers reported in this sample of transgender individuals are similar to those reported in nontransgender samples. Thus, there is no evidence to support that the reported barriers are specific to this sample.

Another limitation of this study is the composition of the sample. It is important for providers to be aware that this sample was skewed toward individuals with higher education and being employed full time; the current sample is highly functioning and mostly insured (95%), therefore limiting its representativeness of the larger transgender population. However, even in this sample of highly educated individuals who could be expected to pursue treatment, cost of mental health services, previous bad experiences, fear or dislike of services, and stigma concerns were primary barriers to seeking treatment, even when distressed. These results emphasize the importance of making efforts to minimize the impact of these barriers in order to facilitate utilization of mental health services. Similarly, it may be said that the high rates of health insurance in the current sample limit generalizability. Though this is true, the current sample is likely representative of transgender individuals who have resources to seek mental health services (e.g., due to employment and health insurance). It is important to note that in Massachusetts health insurance is a requirement for all residents, which may explain the high rate of health insurance coverage in our sample. However, given the lack of population-based studies with transgender persons in the United States, it is not possible to know if the sample is representative.

Despite these limitations, the current study provides new and valuable information that can inform mental health service providers about potential barriers to mental health service utilization in the transgender community. The findings that transgender individuals seek services for a wide range of mental health problems outside of gender identity counseling suggest that providers can provide valuable services to this underserved population. Future research should continue to examine these issues, but the current findings offer guidance for treatment providers on ways to minimize potential barriers that prevent transgender individuals from seeking mental health services.[2]

NOTES

1. It should be noted that according to the World Professional Association for Transgender Health (WPATH) Standards of Care, one letter from a mental health professional (preferably providing gender identity counseling) is required to access hormone therapy or breast surgery and two letters are required to access genital surgery.

2. Providers who are interested in learning more about transgender-sensitive care are referred to www.wpath.com. Or refer to Istar, Arlene (2004). *Transgender emergence: Therapeutic guidelines for working with gender variant people and their families.* The Hawthorne Clinical Practice Press.

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